Health

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Health financing in selected Latin American countries

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1. Introduction

In virtually every country, health services financing is shared between public and private sources. What varies is the dominance in the composition. In general, both in high-income or medium-high income countries, the bulk of health financing stems from public sources[1]. Private funds are spent through out-of-pocket expenses or upon prepayments to private health plans and insurance companies. As old as medicine, direct disbursement is the most unjust and unstable financing; paradoxically, it plays a more important role precisely in the poorest countries (WHO, 2000). In high-income countries, the share of the public sector is on average 62% of total expenditure, while in low-income countries, although such participation has increased in recent years, it does not reach 39% of total expenditure (WHO, 2012).

Health expenditure has grown worldwide. It accounted for 3% of world GDP in 1948. It increased to 8.7% of gross domestic product (GDP) in 2004 (PAHO, 2007). In the period 1998-2003, the average annual growth rate of health expenditure (5.7%) exceeded the average growth rate of world economy, which was 3.6% (HSIAO, 2007).

The amount spent by each country is determined by a number of factors. Some are intrinsic to the system, such as the degree of population coverage, the list of services provided, the extent and speed of adoption

1 One of the exceptions to this rule, perhaps the most important one, is the system of the United States.

of new technologies and the forms of organization, with greater or lesser participation of the Government in conducting and regulating the system. Other factors that may be considered external to the system are the demographic and epidemiological profile of the population, socioeconomic status (income, education, urbanization) and the population's own expectations regarding the services (WHO, 2010; BUSSE et al., 2)

Moreover, a higher level of health expenditure does not automatically translate into more efficient, effective and equitable services. In this respect, systems financing and organization models seem to exert great influence. The United States, for example, whose system is fundamentally based on private insurance, spends 16% of GDP on health annually. However, they have the highest infant mortality rate and the lowest life expectancy among high-income countries (HSIAO, 2006). In turn, with a medical-hospital system that is basically private, with prevailing cash payments (out-of-pocket expenses), India spent 4.8% of GDP on health in 2003 and still had an infant mortality rate five times greater than Sri Lanka, which spent 3.5% of GDP, but with services predominantly financed by public resources (HSIAO, 2007).

Even in the richer countries, there is concern about growth, efficiency, and effectiveness of health expenditure. In turn, the poorest countries that need to increase coverage and improve access to services look for ways to meet the sector's financing needs against other competing investment needs for social and economic development (PIOLA et al., 2008). The aforementioned issues are added to the urgency of improving health financing systems to effectively protect families against catastrophic expenditure[2] and still achieve, via allocation of public funds, greater equity in the access to and use of services[3].

This report discusses health financing in selected Latin American countries, analyzing the evolution of the share of public and private finan-

2 Catastrophic is understood as the unforeseen expenditure that can absorb a significant part of a household's budget, leading it to forgo other consumption, sell assets or even get into debt (see WAGSTAFF; VAN DOORSLAER, 2003; DINIZ et al., 2007).

3 Financing methods should seek out equity in the use of services (PRADHAN; PRESCOTT, 2002; KUTZIN, 2010). This would imply that resources should be distributed proportionally according to the health needs of the population and not according to their ability to pay (WHO, 2000; KUTZIN, 2010).

cial resources and health expenditure trends. The selected countries were: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, El Salvador, Mexico, Paraguay, Peru, Uruguay and Venezuela. Data was tabulated from the Global Health Observatory Data Repository of the World Health Organization.

2. Health expenditure general evolution for the period 2000-2010

Almost all countries analyzed showed growth in per capita total expenditure on health between 2000 and 2010. Some, such as Brazil, Ecuador and Peru, grew over 60%. However, among them, the growth noted in Ecuador was the most surprising, where, according to the data used, per capita expenditure has more than tripled.

The smallest increases occurred in Bolivia, El Salvador and Venezuela, that reported rises slightly above 20% in the period. Paraguay did not follow the trend of other countries, since health expenditure decreased (range -4.4%) (Table 1).

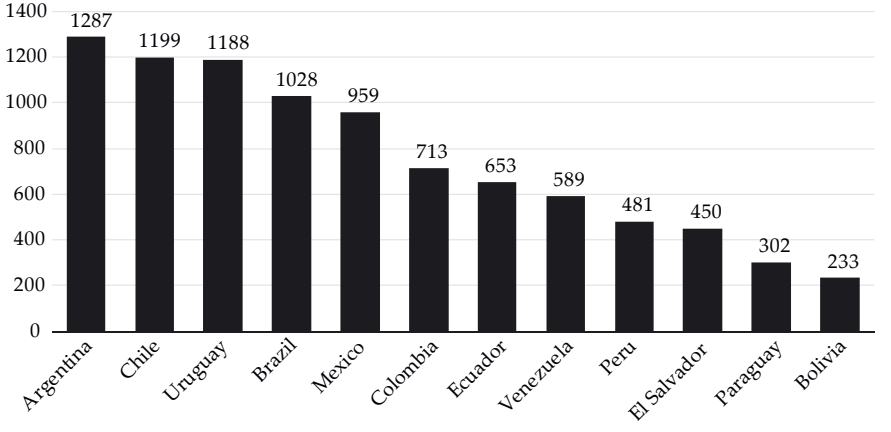
Table 1. Total public and private health expenditure in Latin American countries in per capita values, 2000-2010 – in international dollars (PPP)

Country	2000	2010	Var. %
Argentina	839	1287	53.4
Bolivia	192	233	21.4
Brazil	502	1028	104.8
Chile	768	1199	56.1
Colombia	429	713	66.2
Ecuador	201	653	224.9
El Salvador	367	450	22.6
Mexico	508	959	88.8
Paraguay	316	302	-4.4
Peru	231	481	108.2
Uruguay	719	1188	65.2
Venezuela	482	589	22.2

Source: WHO, Global Health Observatory Data Repository, 2012.

Also regarding total expenditure per capita, very significant variations between countries are observed. At one extreme, there is a group of countries (Argentina, Brazil, Chile and Uruguay) with a per capita expenditure exceeding 1,000 international dollars in 2010. Halfway through, with an expenditure ranging from 500 and 999 international dollars are Mexico, Colombia, Ecuador and Venezuela. At the other extreme, with a per capita expenditure of less than 500 international dollars are Peru (481), El Salvador (450), Paraguay (302) and Bolivia (233) (Table 1 and Chart 1).

Chart 1. Total public and private health expenditure in Latin American countries in per capita values, 2010 – in international dollars (PPP)



Source: WHO, Global Health Observatory Data Repository, 2012.

The relative priority of health expenditure as opposed to other expenditures can also be demonstrated when analyzing the evolution of health expenditure as a proportion of Gross Domestic Product in 2000 and 2010. Although all selected countries, except Paraguay, have shown growth in per capita total health expenditure in the period 2000-2010 (Table 1), in most of them, seven out of 12, total health expenditure as a proportion of GDP decreased (Table 2).

In a context in which all countries analyzed showed a GDP growth in the period, in less than half (five out of 12) health expenditure growth accounted for an increase in health expenditure as a proportion of GDP,

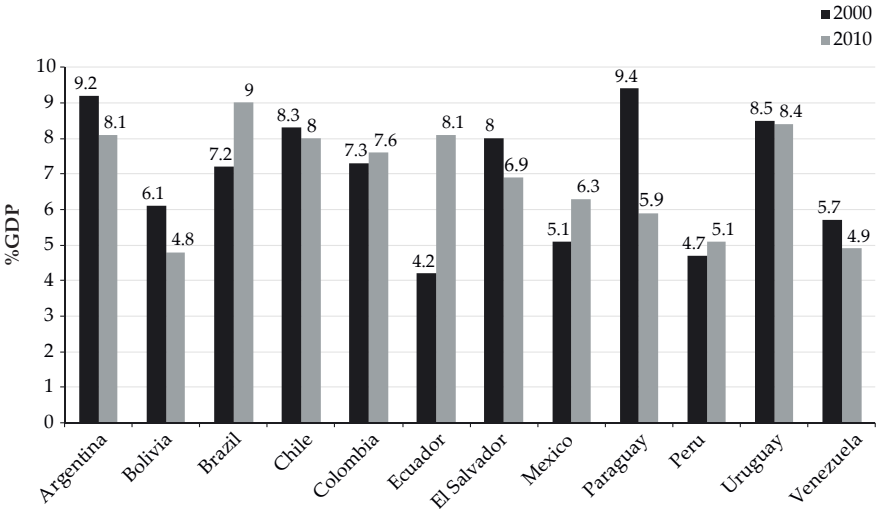
which would constitute an increase in the relative priority of these expenditures. The following countries fit this situation: Brazil, Colombia, Ecuador, Mexico and Peru. In other five countries – Argentina, Bolivia, Chile, El Salvador and Uruguay –, despite registering a health expenditure growth, the share of health spending in GDP decreased. Meanwhile, Paraguay showed a decrease in per capita total expenditure and in the share of health spending in GDP (Tables 1 and 2 and Chart 2).

Table 2. Total public and private health expenditure as a proportion of GDP in Latin American countries, 2000 and 2010

Country	2000	2010	Var. %
Argentina	9.2	8.1	-1.1
Bolivia	6.1	4.8	-1.3
Brazil	7.2	9.0	1.8
Chile	8.3	8.0	-0.3
Colombia	7.3	7.6	0.3
Ecuador	4.2	8.1	3.9
El Salvador	8.0	6.9	-1.1
Mexico	5.1	6.3	1.2
Paraguay	9.4	5.9	-3.5
Peru	4.7	5.1	0.4
Uruguay	8.5	8.4	-0.1
Venezuela	5.7	4.9	-0.8

Source: WHO, Global Health Observatory Data Repository, 2012.

Chart 2. Total health expenditure as a proportion of GDP, 2000 and 2010



Source: WHO, Global Health Observatory Data Repository, 2012.

In short: in the period from 2000 to 2010, all countries, except Paraguay, showed growth in health expenditure in per capita values. However, in only five – Brazil, Colombia, Ecuador, Mexico and Peru – there was concomitantly a growing share of health spending as a proportion of Gross Domestic Product.

3. Public and private mix trends

As in other regions of the world, health expenditure in the countries analyzed in this paper is shared by public and private sources. Therefore, it is important to investigate the financing distribution between public and private sources and especially whether, based on the analysis of relative shares for the years 2000 and 2010, it is possible to check in which segment – public or private – share growth occurred.

For this sample, in six (Argentina, Bolivia, Colombia, El Salvador, Peru and Uruguay) of the 12 countries surveyed public expenditure is higher than private expenditure. In this group, Argentina, Colombia, Peru and Uruguay are considered, according to the World Bank and WHO[4] data, medium-high income countries. The other two, Bolivia and El Salvador, are medium-low income. In turn, in the other six, Brazil, Chile, Ecuador, Mexico, Paraguay and Venezuela, private spending is superior to public. Of these countries, only Paraguay is a medium-low income country; the other five (Brazil, Chile, Ecuador, Mexico and Venezuela) are of medium-high income (Table 3).

Table 3. Health expenditure as a proportion of GDP and allocation of public and private expenditure (%) in Latin American countries, 2010

Countries	Total	Public	% Public	Private	% Private
Argentina	8.1	4.4	54.6	3.7	45.4
Bolivia	4.8	3.0	62.8	1.8	37.2
Brazil	9.0	4.2	47.0	4.8	53.0
Chile	8.0	3.9	48.2	4.1	51.8
Colombia	7.6	5.5	72.7	2.1	27.3
Ecuador	8.1	3.0	37.2	5.1	62.8
El Salvador	6.9	4.3	61.7	2.6	38.3
Mexico	6.3	3.1	48.9	3.2	51.1
Paraguay	5.9	2.1	36.4	3.8	63.6
Peru	5.1	2.8	54.0	2.3	46.0
Uruguay	8.4	5.6	67.1	2.8	32.9
Venezuela	4.9	1.7	34.9	3.2	65.1

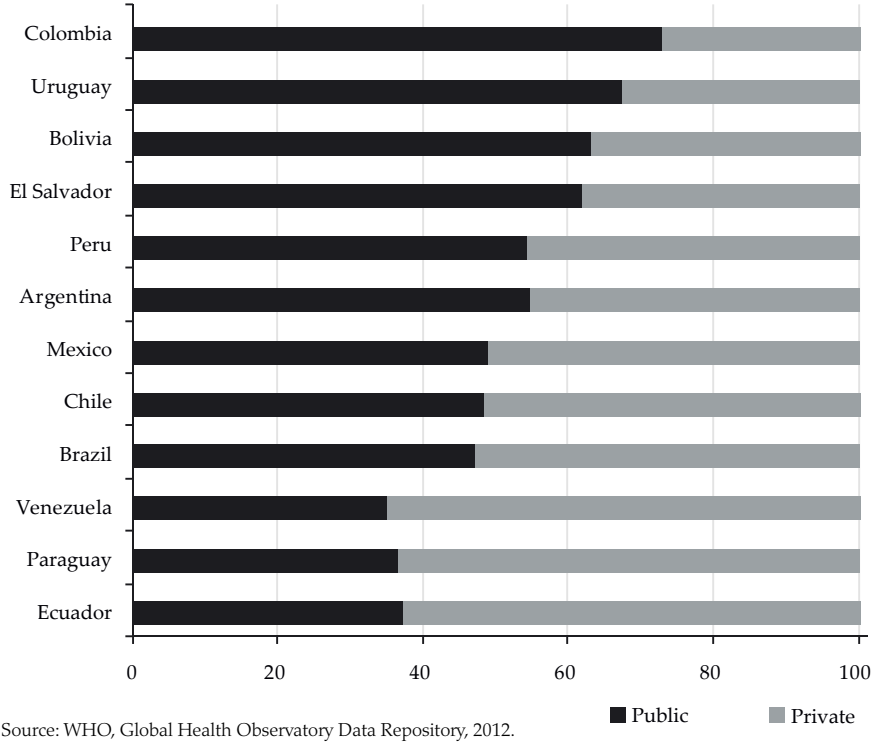
Source: WHO, Global Health Observatory Data Repository, 2012.

As can be seen in data from WHO (2012), countries with lower per capita income generally have proportionally lower public expenditure than private expenditure. This trend is not evident in the sample coun-

4 World Bank list of economies (November, 2011), Washington, D.C., World Bank, 2011 (http://siteresources.worldbank.org/DATASTATISTICS/Resources/CLASS.XLS). Apud: WHO, 2012.

tries. Bolivia and El Salvador do not follow this trend, which is, however, confirmed by Paraguay. However, the most striking is that among some of the highest-income countries, located as medium-high income countries, public expenditure is lower than private one. This is the case of Brazil, Chile, Mexico and Venezuela, which contradict the trend that in countries with highest income public share is almost always higher. The Brazilian case is paradoxical because it is the only one, of the four mentioned above, that, by constitutional mandate, has a health system responsible to provide universal access and comprehensive care since the Constitution of 1988 (Table 3 and Chart 3).

Chart 3. Share of public and private sources in the total expenditure on health in selected Latin American countries, 2010



Source: WHO, Global Health Observatory Data Repository, 2012.

No less important is to identify where responsibility for health financing is leaning. That is, which grows faster: public or private financing? With this objective, comparing the share of both in health financing in 2000 and 2010, it can be observed that public share has grown in eight (Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, El Salvador and Mexico) of the 12 countries. Of these countries, in three (Argentina, Bolivia and Colombia), public sources already had a dominant share of total health expenditure. El Salvador changed the composition in the period: in 2000, public sources accounted for 45.2% of total spending and, in 2010, this share reached a percentage of 61.7%. In the other four countries, Brazil, Chile, Ecuador and Mexico, despite the growth of public participation in financing, most of the resources continue to come from private sources.

In turn, private participation grew in four countries: Paraguay, Peru, Uruguay and Venezuela. Two of them, Paraguay and Venezuela, have a higher private than public participation in financing. Private sources contributed with 63.6% of total health expenditures in Paraguay and 65.1% in Venezuela, in 2010. On the other hand, Uruguay and Peru, despite the growth of private share, continue with systems funded mostly by public sources. In Uruguay, in 2010, 67.1% were public resources and, in Peru, in the same year, the percentage of public resources was 54% (Table 4).

Table 4. Share (%) of public and private funds in total health expenditure in Latin American countries, 2000 and 2010

	% Public		% Private	
Countries	**2000**	**2010**	**2000**	**2010**
Argentina	53.9	54.6	46.1	45.4
Bolivia	60.1	62.8	39.9	37.2
Brazil	40.3	47.0	59.7	53.0
Chile	41.6	48.2	58.4	51.8
Colombia	70.7	72.7	29.3	27.3
Ecuador	31.2	37.2	68.8	62.8
El Salvador	45.2	61.7	54.8	38.3
Mexico	46.6	48.9	53.4	51.1
Paraguay	39.9	36.4	60.1	63.6
Peru	58.7	54.0	41.3	46.0
Uruguay	72.3	67.1	27.7	32.9
Venezuela	41.5	34.9	58.5	65.1

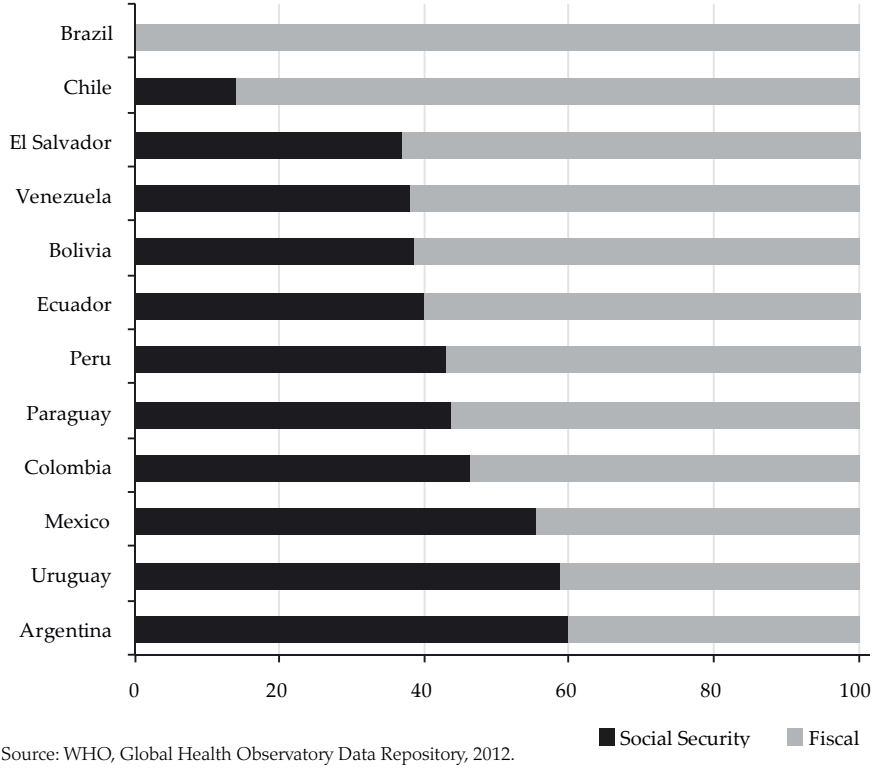
Source: WHO, Global Health Observatory Data Repository, 2012.

Regarding the internal composition of public financing in the analyzed countries, with the exception of Brazil, all countries count, aside fiscal resources, with Social Security[5] revenues, primarily, contribution on payroll, in a greater or lesser volume. Since 1993, Brazil no longer counts on Social Security income as a source of public funding for health. In some countries, such as Argentina, Mexico and Uruguay, social security resources corresponded in 2010 to 59.4%, 55.4% and 58.8%, respectively, of total public spending. In all others, except for Chile, the social security participation varied from 36.9% (El Salvador) to 46.4% (Colombia) of the public spending. In Chile, this share stood at 14.2% in the same year of 2010. That is, with the exception of Brazil and Chile, the share of social security resources in an important source in health public financing (Chart 4). However, in terms of trend and considering the evolution of social security share in 2000 and 2010, it can be stated that there is a propensity to diminish social security resources in public health spending and increase fiscal resources. Only in three countries, Ecuador, Uruguay and Venezuela, there was increased participation. In Argentina and Chile there was main-

5 Correspond to the social insurance public systems existing in Latin American countries.

tenance of the participation percentage of the social security sources and, in the other six countries (Bolivia, Colombia, El Salvador, Mexico, Paraguay and Peru) there was a decrease (Table C of Annex).

Chart 4. Percentage composition of public funding according fiscal and social security sources in Latin American countries, 2010



Source: WHO, Global Health Observatory Data Repository, 2012.

The composition of private spending is also important in analytical terms. In general, there is a justified concern with out-of-pocket expenses (OOP) due to two adverse effects of this practice in the process of building a more equitable health system. Firstly, OOP can restrict access to services (WHO, 2010), especially when used as a form of participation in the financing of public services (copayment). Second, because systems with strong participation of pocket payments, especially in the absence of a public

system with more effective coverage, may subject families to make unanticipated expenditures with the health of its members, which can absorb a significant part of household budgets, leading the family to restrict the consumption of other goods, sell assets or go into debt. That is, health expenditure may reach catastrophic proportions for these families. In turn, the prepayment schemes organized in the form of pooling for private plans and insurance can minimize these risks, which are diluted among all users of this type of services. Therefore, it is also interesting to identify, in the case of private spending, which is the evolution of out-of-pocket expenses and private forms of prepayment. Table 5 below shows the share of direct and mediate spending through prepayment forms (insurance and private health plans) in the total spending for selected countries.

Table 5. Share (%) of out-of-pocket and plans and insurance expenditure in the total private expenditure in Latin American countries, 2000 and 2010

	Out-of-pocket expenditure		Plans and Insurance	
Country	**2000**	**2010**	**2000**	**2010**
Argentina	63.0	65.8	30.7	25.3
Bolivia	81.6	77.2	8.1	19.1
Brazil	63.6	57.8	34.3	40.4
Chile	62.2	64.3	37.8	35.7
Colombia	76.7	71.5	23.3	28.5
Ecuador	85.3	78.0	4.8	12.4
El Salvador	94.6	88.6	5.4	11.4
Mexico	95.3	92.2	4.7	7.8
Paraguay	86.6	89.7	13.4	10.3
Peru	81.3	85.8	15.0	10.9
Uruguay	67.7	39.6	32.3	60.4
Venezuela	90.9	90.6	2.2	3.4

Source: WHO, Global Health Observatory Data Repository, 2012.

In all countries, except Uruguay, out-of-pocket expenditure accounts for the greater share of private expenditure. In 2010, out-of-pocket expen-

ses in selected countries corresponded between 39.6% in Uruguay and 92.2% of private expenditure in Mexico. In Uruguay, 60.4% of private expenditure is due to private health plans and insurance. Other countries with a significant percentage of prepaid expenditure are Brazil (40.4%), Chile (35.7%), Colombia (28.5%) and Argentina (25.3%).

On average, out-of-pocket expenditure is equivalent to more than 75% of private expenditure in the countries analyzed in 2010. It would be important to better identify the features of out-of-pocket expenditure in these countries, but this approach exceeds the scope of this work. Studies performed for Brazil show that the poorest deciles of the population spend proportionately more of their household income on health care. Out-of--pocket expenditures in these income strata aim at – mostly, more than 75% – purchasing drugs. At all income levels, most of household expenditure – except for the payment of private health plans and insurance – is for the purchase of drugs and dental care (SILVEIRA, 2007).

Anyway, prepaid plans, a typical method of health plans and insurance segments, are increasing within private expenditure, which is interesting given the inequity and instability of out-of-pocket expenditure. In two thirds of the countries analyzed (Bolivia, Brazil, Colombia, Ecuador, El Salvador, Mexico, Uruguay and Venezuela), there was an increased share of this financing method in the private segment. Noteworthy is, however, the low share of prepaid plans in private funding in Ecuador (12.4%), El Salvador (11.4%), and, mostly, Mexico (7.8%) and Venezuela (3.4%), well below the share rates found in other countries.

4. Final considerations

From 2000 to 2010, almost all analyzed countries recorded growth in total health expenditure per capita values. The exception was Paraguay, which had no growth. However, in only five countries – Brazil, Colombia, Ecuador, Mexico and Peru – there was, concomitantly, a growth in the participation of health expenditure as a proportion of GDP. In seven countries, the share of health expenditure in GDP has decreased, although per capita spending has grown.

Regarding composition, public health spending is higher than private in six (Argentina, Bolivia, Colombia, El Salvador, Peru and Uruguay) of the 12 countries analyzed. The remarkable thing, however, is that in some higher-income countries (Brazil, Chile, Mexico and Venezuela), public expenditure is lower than private, contrary to the situation generally found of higher public spending in medium-high and high-income countries.

From 2000 to 2010, public share in health financing grew in eight of the 12 countries: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, El Salvador and Mexico. Among these countries, despite growing public participation in financing, the public share remains lower than the private in Brazil, Chile, Ecuador and Mexico. Furthermore, in almost all countries, except Ecuador, Venezuela and Uruguay, there was an increase in the participation of fiscal resources in the composition of public spending.

On average, out-of-pocket expenditure accounts for more than 75% of private expenditure in the countries analyzed in 2010. However, there has been a growth of prepaid plans in private expenditure, related to the segment of health plans and insurance, which, if properly regulated, can reduce the household's financial risk. In two thirds of the countries analyzed, there was an increased share of this segment in private financing.

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Annexes

Table A. Per capita total expenditure on health (PPP int. $)

Country	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Argentina	839	830	658	724	806	916	1017	1125	1218	1386	1287
Bolivia	192	203	215	189	190	210	192	199	223	237	233
Brazil	502	521	530	528	576	695	767	828	862	921	1028
Chile	768	816	835	780	798	843	864	959	1094	1209	1199
Colombia	429	438	449	494	510	544	581	619	622	687	713
Ecuador	201	238	295	366	402	430	473	507	551	692	653
El Salvador	367	372	379	376	388	407	403	405	408	439	450
Mexico	508	552	584	629	688	730	776	842	891	920	959
Paraguay	316	311	296	255	248	253	271	271	283	295	302
Peru	231	232	252	248	256	285	317	396	497	466	481
Uruguay	719	699	642	582	736	797	858	897	977	1099	1188
Venezuela	482	523	452	433	492	537	633	701	686	734	589

Source: WHO, Global Health Observatory Data Repository, 2012.

Table B. Total expenditure on health as a percentage of gross domestic product

Country	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Argentina	9.2	9.4	8.3	8.3	8.3	8.5	8.5	8.4	8.4	9.5	8.1
Bolivia	6.1	6.3	6.5	5.6	5.3	5.6	4.8	4.7	4.9	5.1	4.8
Brazil	7.2	7.3	7.2	7.0	7.1	8.2	8.5	8.5	8.3	8.8	9.0
Chile	8.3	8.4	8.4	7.5	7.1	6.9	6.6	6.9	7.5	8.4	8.0
Colombia	7.3	7.3	7.3	7.7	7.4	7.4	7.3	7.2	6.9	7.6	7.6
Ecuador	4.2	4.6	5.5	6.6	6.6	6.6	6.7	7.0	7.0	8.8	8.1
El Salvador	8.0	7.8	7.7	7.3	7.2	7.1	6.6	6.3	6.2	6.8	6.9
Mexico	5.1	5.5	5.6	5.8	6.0	5.9	5.7	5.8	5.9	6.5	6.3
Paraguay	9.4	9.1	8.7	7.2	6.6	6.5	6.6	6.1	6.0	6.6	5.9
Peru	4.7	4.7	4.8	4.5	4.4	4.5	4.5	5.1	5.7	5.3	5.1
Uruguay	8.5	8.4	8.2	7.2	8.5	8.3	8.3	7.9	7.7	8.4	8.4
Venezuela	5.7	6.0	5.7	5.9	5.6	5.4	5.7	5.8	5.4	6.0	4.9

Source: WHO, Global Health Observatory Data Repository, 2012.

Table C. Social security expenditure on health as a percentage of general government expenditure on health

Country	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Argentina	59.5	58.9	58.3	57.3	57.8	57.6	58.3	58.6	58.5	59.4	59.4
Bolivia	62.0	65.2	65.0	49.5	49.9	44.4	44.6	41.0	39.2	38.3	38.6
Brazil	0	0	0	0	0	0	0	0	0	0	0
Chile	15.0	15.7	16.0	12.4	13.0	14.3	13.9	14.2	14.5	14.2	14.2
Colombia	60.2	66.3	63.9	66.0	67.9	69.5	70.1	70.1	70.1	48.6	46.4
Ecuador	28.0	32.2	32.0	41.2	53.5	53.0	59.6	54.6	52.2	38.3	39.6
El Salvador	44.2	41.2	44.5	42.9	43.2	45.7	47.3	43.2	41.1	37.5	36.9
Mexico	67.6	66.7	66.1	66.9	67.3	62.0	60.2	58.9	55.2	54.6	55.4
Paraguay	52.4	47.3	38.8	41.7	41.8	41.9	38.6	41.5	49.7	57.0	43.6
Peru	49.5	47.5	47.7	46.6	46.0	46.0	40.5	35.5	32.5	44.5	43.0
Uruguay	27.4	25.7	25.9	25.1	52.6	59.2	55.0	49.3	57.5	57.9	58.8
Venezuela	34.6	34.0	35.6	35.5	36.2	32.5	32.4	33.7	31.4	30.8	38.1

Source: WHO, Global Health Observatory Data Repository, 2012.

Table D. General government expenditure on health as a percentage of total expenditure on health

Country	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Argentina	53.9	54.2	53.6	52.3	52.3	54.2	55.8	59.4	62.6	66.4	54.6
Bolivia	60.1	59.3	62.8	60.1	62.6	66.2	69.9	68.2	65.1	64.6	62.8
Brazil	40.3	42.3	44.6	44.4	47.0	40.1	41.7	41.8	42.8	43.6	47.0
Chile	41.6	42.9	43.8	38.8	39.9	40.0	42.1	43.2	44.1	47.6	48.2
Colombia	70.7	70.3	70.4	70.1	70.6	70.0	70.8	71.1	70.6	71.1	72.7
Ecuador	31.2	34.5	33.7	22.1	23.0	22.3	23.8	24.3	26.5	34.9	37.2
El Salvador	45.2	45.4	46.6	47.3	49.3	52.6	62.0	59.1	59.4	60.3	61.7
Mexico	46.6	44.8	43.8	44.2	45.2	45.0	45.2	45.4	47.0	48.3	48.9
Paraguay	39.9	34.9	33.2	33.1	34.8	37.9	41.1	40.5	40.9	39.0	36.4
Peru	58.7	57.9	57.6	58.7	58.8	59.4	56.3	58.5	62.3	57.7	54.0
Uruguay	72.3	71.9	70.8	68.0	49.3	50.7	53.1	54.6	63.8	65.3	67.1
Venezuela	41.5	40.7	39.3	38.1	41.4	43.3	41.7	46.5	44.9	40.0	34.9

Source: WHO, Global Health Observatory Data Repository, 2012.

Table E. Private expenditure on health as a percentage of total expenditure on health

Country	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Argentina	46.1	45.8	46.4	47.7	47.7	45.8	44.2	40.6	37.4	33.6	45.4
Bolivia	39.9	40.7	37.2	39.9	37.4	33.8	30.1	31.8	34.9	35.4	37.2
Brazil	59.7	57.7	55.4	55.6	53.0	59.9	58.3	58.2	57.2	56.4	53.0
Chile	58.4	57.1	56.2	61.2	60.1	60.0	57.9	56.8	55.9	52.4	51.8
Colombia	29.3	29.7	29.6	29.9	29.4	30.0	29.2	28.9	29.4	28.9	27.3
Ecuador	68.8	65.5	66.3	77.9	77.0	77.7	76.2	75.7	73.5	65.1	62.8
El Salvador	54.8	54.6	53.4	52.7	50.7	47.4	38.0	40.9	40.6	39.7	38.3
Mexico	53.4	55.2	56.2	55.8	54.8	55.0	54.8	54.6	53.0	51.7	51.1
Paraguay	60.1	65.1	66.8	66.9	65.2	62.1	58.9	59.5	59.1	61.0	63.6
Peru	41.3	42.1	42.4	41.3	41.2	40.6	43.7	41.5	37.7	42.3	46.0
Uruguay	27.7	28.1	29.2	32.0	50.7	49.3	46.9	45.4	36.2	34.7	32.9
Venezuela	58.5	59.3	60.7	61.9	58.6	56.7	58.3	53.5	55.1	60.0	65.1

Source: WHO, Global Health Observatory Data Repository, 2012.

Table F. Out-of-pocket expenditure as a percentage of private expenditure on health

Country	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Argentina	63.0	64.0	64.2	64.4	64.1	64.3	64.1	61.5	59.2	59.2	65.8
Bolivia	81.6	77.9	78.9	79.1	78.3	77.8	70.4	72.9	77.2	77.2	77.2
Brazil	63.6	62.6	62.5	62.6	62.6	62.8	61.8	58.5	56.0	57.2	57.8
Chile	62.2	62.8	63.4	63.6	64.6	65.0	65.6	64.4	65.2	64.6	64.3
Colombia	76.7	76.1	77.2	76.6	76.2	76.9	76.1	76.4	76.3	74.8	71.5
Ecuador	85.3	87.0	87.9	89.6	87.3	86.8	78.4	76.4	75.4	75.4	78.0
El Salvador	94.6	93.1	93.4	93.3	92.5	91.7	88.9	89.0	88.8	87.9	88.6
Mexico	95.3	95.0	94.9	94.7	94.7	94.0	93.6	93.1	92.9	92.3	92.2
Paraguay	86.6	84.9	85.6	84.9	85.2	87.1	87.6	88.3	89.2	89.7	89.7
Peru	81.3	81.1	82.0	78.8	79.2	79.4	82.1	85.4	86.5	84.7	85.8
Uruguay	67.7	67.3	65.5	67.0	32.4	32.1	31.1	29.9	33.8	40.0	39.6
Venezuela	90.9	92.1	92.6	92.6	91.0	89.4	88.0	88.1	89.5	90.6	90.6

Source: WHO, Global Health Observatory Data Repository, 2012.

Table G. Private prepaid plans as a percentage of private expenditure on health

Country	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Argentina	30.7	29.3	28.4	28.4	28.3	28.5	28.4	30.7	32.8	32.8	25.3
Bolivia	8.1	12.0	10.8	16.6	17.8	19.4	24.2	22.6	19.1	19.1	19.1
Brazil	34.3	35.0	34.8	34.9	34.9	35.5	36.4	39.8	42.2	41.0	40.4
Chile	37.8	37.2	36.6	36.4	35.3	35.0	34.4	35.5	34.8	35.4	35.7
Colombia	23.3	23.9	22.8	23.4	23.8	23.1	23.9	23.6	23.7	25.2	28.5
Ecuador	4.8	3.1	4.5	3.7	4.8	5.4	9.1	11.4	12.0	12.0	12.4
El Salvador	5.4	6.9	6.6	6.7	7.5	8.3	11.1	11.0	11.2	12.1	11.4
Mexico	4.7	5.0	5.1	5.3	5.3	6.0	6.4	6.9	7.1	7.7	7.8
Paraguay	13.4	15.1	14.4	15.1	14.8	12.9	12.4	11.7	10.8	10.3	10.3
Peru	15.0	15.2	14.5	17.7	17.1	17.3	14.5	11.3	10.2	12.1	10.9
Uruguay	32.3	32.7	34.5	33.0	67.6	67.9	68.9	70.1	66.2	60.0	60.4
Venezuela	3.2	3.1	3.2	3.1	3.1	3.1	2.7	3.2	3.3	3.4	3.4

Source: WHO, Global Health Observatory Data Repository, 2012.